PROVINCIAL SENIOR CITIZENS ADVISORY COUNCIL

ANNUAL REPORT 1984

Report submitted to the Honourable Neil Webber
Minister of Alberta Social Services and Community Health

December 1984

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EXECUTIVE SUMMARY

In this 1984 report, the Provincial Senior Citizens Advisory Council recognizes that many of the factors that contribute to a richer and fuller life in the later years are the responsibility of older people themselves, their families and of society in general. We are suggesting areas in which government can provide helpful supports that would allow these groups to continue this responsibility.

Council sees adequate income as essential and after reviewing the Department of Labour's discussion paper, "Proposals for Improving the Private Pension Plan System in Alberta," has endorsed or amended some of its recommendations. Suggestions are also made about flexible retirement options that would enable businesses to continue to use the expertise of older citizens.

This year we stress the importance of senior centres as self-help groups with mutual networks of support, sharing and advocacy for older people and as resource groups for the community-at-large. We commend the steps already taken in the development of physical fitness programs for older persons and recommend that opportunities for such programs be increased. We have also examined the role of Local Health Units in health promotion and preventive health care for the elderly and recommend that ways be developed to widen this role, in particular through the use of mobile vans with health education materials. We also are convinced that education about aging should begin in elementary schools and continue into programs for retirement planning and educational opportunities for the retired. We present one way of working with junior high students.

Council has been concerned about the dissemination of information to the elderly so they can become aware of what is available for them. One way that this can be achieved is by the use of senior volunteers as consultants for senior centres and the community.

We also believe that some encouragement should be given to middle and upper income people to consider what type of housing will best suit their retirement needs.

Council has always encouraged the development of alternatives to institutional care. Recently we have been encouraged by the increase of funding for Home Care and the work which has been done by the Interdepartmental Committee on Long Term Care in creating a model for an assessment/placement service (a single entry point). Council sees it as essential that Home Care be this entry point for all long-term care services. In 1983, Council made a recommendation that consideration be given to placing the Coordinated Home Care Program under its own management. In this report we suggest that discussion should be initiated on this point.

In its last report Council proposed that standards be established for lodges. The Alberta Senior Citizens' Homes Association has developed these but ways to assure that the standards are being achieved still have to be set in place. We are suggesting that a committee of representatives from the Alberta Senior Citizens' Homes Association and the Alberta Mortgage and Housing Corporation oversee the implementation of these standards.

Day hospitals and day care centres are other services that will enable some elderly to remain in the community. These and alarm systems are examined as important ways of giving support to some elderly, who would like to remain independent, as well as support to their families.

Council has been concerned with the needs of older persons with psychiatric problems, and in this report it recommends special units for the mentally disturbed who are in nursing

homes and auxiliary hospitals.

Because of the continuing increase in health care expenses and the varying costs of continuing care that, at times, lead a person to seek a higher level of care since it is less expensive, Council recommends that residents pay the cost of room and board and that these costs be the same for lodges, nursing homes and auxiliary hospitals. Council continues to support the developments at the University of Calgary for geriatric education which call for a geriatric component in the medical program that will utilize existing resources at the Foothills Hospital. This should provide expert consultation services for older patients in Southern Alberta. In many cases such a service could prevent the need for long-term care.

Council has established a Research Subcommittee to administer the granting of research funds approved by the Minister of Social Services and Community Health on the recommendation of Council in 1983. The Subcommittee has set guidelines and priorities for research proposals, and a number have been received. Such research will improve the well-being of older persons and will encourage the proper use of resources.

SUMMARY OF RECOMMENDATIONS

RECOMMENDATION ONE: FLEXIBLE RETIREMENT PRACTICES AND WORK OPTIONS

TO THE MINISTERS OF LABOUR AND MANPOWER

The Council recommends that the Departments encourage the development of more flexible retirement practices such as extending the retirement age and work options through part-time, contractual and relief work. This could be encouraged through mutual agreement between employer and employee.

RECOMMENDATION TWO: CANADA PENSION PLAN

TO THE MINISTERS OF FEDERAL AND INTERGOVERNMENTAL AFFAIRS, LABOUR AND SOCIAL SERVICES AND COMMUNITY HEALTH AND TO THE PROVINCIAL TREASURER

The Council recommends that the Government of Alberta support an expansion of the Canada Pension Plan, that employee payments (1.8 percent of salary of the employee, up to an annual income of approximately $20,000) be increased gradually (half a percentage point per year) up to 4 percent a year for the employee and 4 percent a year for the employer, that the benefits paid to retired persons be increased (possibly doubled) over a period of time, and that self-employed persons be required to pay into the Canada Pension Plan.

RECOMMENDATION THREE: PRIVATE PENSION PLANS

TO THE MINISTER OF LABOUR AND THE PROVINCIAL TREASURER

The Council recommends

- that the Government encourage the expansion of indexed private pension plans through special appropriate tax incentive programs for the employer and through educational programs about the benefits of such plans;
- that where there is a private pension plan, all permanent full-time and part-time employees be required to participate;
- that vesting provisions (now mostly ten years) be relaxed, dropping to five years or less;
- that the portability of private pension benefits be improved by providing the option that the value of the terminating employee's benefits be transferred into an equivalent of a "locked-in" RRSP;
- that upon marriage breakdown the vested pension benefits be split equally between the spouses but remain as "locked-in" pension benefits until retirement;
- that employees be entitled to full information about the status of their pension plans and that annual statements showing the accrued benefits be available from all pension plans;
- that the Government continue to regulate the investment of private pension plan funds;
- that married employees be required to choose a survivor's benefit option, providing that at least 60 percent of the original pension will continue should the retired employee die.

RECOMMENDATION FOUR: RETIREMENT SAVINGS

TO THE MINISTER OF LABOUR AND THE PROVINCIAL TREASURER

The Council recommends that Registered Retirement Savings Plans and private pension plans be further encouraged through tax incentive measures in which the Government would ensure that the amount of funds so invested could be deducted from one's present taxable income (tax deferred until funds drawn out) with an appropriate upper limit set on the amount.

RECOMMENDATION FIVE: VOLUNTARY COMMUNITY CONSULTANTS

TO THE MINISTERS OF CULTURE, RECREATION AND PARKS, AND SOCIAL SERVICES AND COMMUNITY HEALTH

The Council recommends that the Departments work with the Alberta Council on Aging and the federal New Horizons program to develop a corps of retired persons to work as consultants to organized senior centres, developing senior centres and other senior groups.

RECOMMENDATION SIX: PHYSICAL FITNESS INSTRUCTORS

TO THE MINISTER OF RECREATION AND PARKS

The Council recommends that more physical fitness instructors be trained to work with the general public of all age levels, including seniors, and with elderly persons living in lodges and nursing homes, and that local recreation boards be encouraged to include senior citizen representatives.

RECOMMENDATION SEVEN: EDUCATION ABOUT AGING

TO THE MINISTER OF EDUCATION

The Council recommends that the pilot project presented to the Calgary Separate School system described in Appendix C be evaluated by the Department and, if it proves worthwhile, it or similar material be incorporated into the curriculum options on a province-wide basis.

RECOMMENDATION EIGHT: MOBILE HEALTH CARE VANS

TO THE MINISTER OF SOCIAL SERVICES AND COMMUNITY HEALTH

The Council recommends that the Department sponsor two mobile health care vans that would be accompanied throughout the province by a Community Health Nurse, would contain materials on the holistic, preventive and self-care aspects of health and would be made available to senior residences, lodges, senior centres, and senior groups.

RECOMMENDATION NINE: HOUSING FOR SENIORS

TO THE MINISTER OF HOUSING

The Council recommends that the Department continue its support of specially-designed homes

for older persons who are in the middle income brackets and that consideration be given to developing more support staff in some already existing seniors' apartments.

RECOMMENDATION TEN: ADMINISTRATION OF THE COORDINATED HOME CARE PROGRAM

TO THE MINISTER OF SOCIAL SERVICES AND COMMUNITY HEALTH

The Council recommends that a study be undertaken to look at the advisability of separating two very different types of delivery of health programs (Community Health and Home Care) now under one administration, the Health Unit Board.

RECOMMENDATION ELEVEN: ADULT DAY CARE

TO THE MINISTERS OF HOSPITALS AND MEDICAL CARE AND SOCIAL SERVICES AND COMMUNITY HEALTH

The Council recommends that the Departments plan the scope, funding, delivery and evaluation of two or three more pilot day care programs for the frail and handicapped elderly in locations other than Edmonton.

RECOMMENDATION TWELVE: STANDARDS FOR LODGES

TO THE MINISTER OF HOUSING

The Council recommends that the Minister appoint a committee, which would include representatives from the Alberta Senior Citizens' Homes Association and the Alberta Mortgage and Housing Corporation, to oversee the implementation of the lodge standards.

RECOMMENDATION THIRTEEN: PSYCHOGERIATRIC CARE

TO THE MINISTER OF HOSPITALS AND MEDICAL CARE

Council endorses the recommendation of the Provincial Mental Health Advisory Council that only patients suitable for nursing home care should be admitted or maintained in regular nursing homes. Some nursing homes and auxiliary hospitals interested in having special units for mentally disturbed older persons should be funded to develop specific programs for these patients.

RECOMMENDATION FOURTEEN: CHARGES FOR LODGES, NURSING HOMES AND AUXILIARY HOSPITALS

TO THE MINISTER OF HOSPITALS AND MEDICAL CARE AND THE MINISTER OF HOUSING

The Council recommends that residents in continuing care facilities pay the cost of their room and board, that the room and board charges for all three facilities (lodges, nursing homes and auxiliary hospitals) be the same and that the 120 initial free days in an auxiliary hospital be removed

(persons should start paying when admitted), if and when the auxiliary is designated as the permanent residence of the individual.

RECOMMENDATION FIFTEEN: EDUCATION IN GERONTOLOGY

TO THE MINISTER OF SOCIAL SERVICES AND COMMUNITY HEALTH

The Council recommends that an appropriate grant be made available to underwrite the costs of a conference to discuss the coordination of plans for education in gerontology.

RECOMMENDATION SIXTEEN: EDUCATION IN GERIATRICS

TO THE MINISTERS OF ADVANCED EDUCATION, HOSPITALS AND MEDICAL CARE AND SOCIAL SERVICES AND COMMUNITY HEALTH

The Council recommends that an appropriate annual grant be made to the University of Calgary for an initial period of seven years to permit the establishment of a Chair of Geriatrics, the appointment of one additional faculty member, one psychologist and the necessary secretarial services.

PROVINCIAL SENIOR CITIZENS ADVISORY COUNCIL 1984

Chairman: Raymond Clark
Bow Island

John P. Donahue
Calgary Area

Marguerite Garrett
Red Deer Area

Erna Goertzen
Lethbridge Area

Sister Jean Golden
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Arta Juneau
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Muriel Oslie
Peace River

Donna Rose
Bassano

Representing the Universities-

Professor A.E.D. Schonfield
University of Calgary

PROVINCIAL SENIOR CITIZENS ADVISORY COUNCIL

TERMS OF REFERENCE

Purpose

1. To review the views and concerns of older persons in Alberta.
2. To foster positive attitudes towards aging and a better understanding of old people.
3. To provide advice to the government on specific policies and programs for senior citizens and to advise in regard to priorities and the co-ordination of programs.
4. To make any other observations to the government deemed to be relevant to the development of programs for older people.
5. To review and advise on educational and special projects grants for programs for senior citizens, subject to the availability of funds.
6. To carry out other responsibilities at the request of the government from time to time.

Structure

Meetings

- The Council will meet not less often than four times a year.

Reporting

- The Council shall submit an annual report to the Minister responsible for the Council at the end of each calendar year and submit any other reports to the Minister deemed appropriate.

Remuneration of the Chairman and Members of Council

- Remuneration, honoraria and out-of-pocket expenses will be according to the appropriate schedule established by Ministerial Order. Honoraria will not be paid to public servants.

Secretariat

- The Director of the Senior Citizens Bureau will act in this capacity and the resources of this office will be available to the Council.

Membership

- Chairman to be appointed by government and to hold ofice at the pleasure of the government.
- One member from each of the following organizations selected from nominations put forward by them: Alberta Hospital Association, Alberta Medical Association, and on an alternating basis, the University of Calgary, the University of Alberta and the University of Lethbridge.
- One Member of the Legislature.
- Ten members representing the community.

INTRODUCTION

We are pleased to submit this eighth annual report to the Minister of Social Services and Community Health. In doing so, we would like to take this opportunity in the introduction to express appreciation to the Government for the careful and continuing consideration it has given to our recommendations and to review briefly our past activities.

In looking back, we note that our first action as a Council was to develop a statement of philosophy or principles which we believed should form the foundation of Government social policies for senior citizens. It was our conviction that we should use these as a guide in developing our reports and recommendations. Briefly, there should be

- provision of maximum independence and choice;
- encouragement of continued participation in family and community life;
- involvement of senior citizens in the planning, development and assessment of services.

One of our major concerns has been the need to coordinate government policy, programs and services relating to senior citizens. We appreciate that an Interdepartmental Committee on Long Term Care composed of senior officials has been established to discuss issues in common among the three departments and the Corporation providing long-term care services for older persons (home care, lodges, nursing homes and auxiliary hospitals).

Adequate income support is essential for older persons. The increases in the Alberta Assured Income Plan and the introduction of the Alberta Widows' Pension are steps in the right direction.

We feel that home care is a most crucial service in maintaining older persons in their familiar surroundings, with their family and friends. The recent expansion of home care, both the increased funds and the expanded eligibility criteria, is most welcome. This will ensure that home care will become a truly comprehensive support service.

The Council believes, and has emphasized, that older persons should not move into long-term institutional care without a careful assessment to determine the appropriate treatment and rehabilitation program needed, and without consideration being given to providing needed service in the home or on an out-patient basis. A joint assessment procedure with home care was suggested in the 1980 report. Steps are now being taken, with the development of a model for a coordinated assessment and placement service, to test this principle in two or three regions of the province.

For each of our reports we have had background papers prepared to provide more information to support our recommendations. Appendix A contains a list of these papers which, in addition to being included in the reports, have been distributed by the Senior Citizens Bureau. They have been of interest and helpful to the general public.

Throughout all the years, we have emphasized that the Government should stress "prevention" in social policy for the elderly. All programs should be directed as much as possible towards helping older persons maintain good morale and health. This requires more concern for programs of prevention and self-care such as senior centres and recreation services, health promotion, home-delivered care and day services. Such a shift should enable us to curtail the growing costs connected with the *care* of older persons.

The number of senior citizens is expected to double in Alberta by the turn of the century and the proportion of those in the senior population age 85 and over (those who are the heaviest

users of care services) to increase. A Canadian Medical Association Task Force Report[1] suggests that if current patterns of providing care remain unchanged demographic changes alone will increase current expenditures dramatically, and there will need to be large capital expenditures for the building of more institutions. The Task Force points out the savings that could take place by lowering the current high rate of institutionalization of the elderly in Canada to a rate similar to that of the United States, the United Kingdom and Australia.

To shift the emphasis in services to efforts to maintain older persons in a state of health and to keep them as independent as possible would be both cost-effective and rational and, more importantly, better for their quality of life.

Therefore, we are continuing this thrust for a "new approach" in our 1984 report. We are submitting recommendations in Section I concerning the pension system in Canada. Adequate income is essential to health and morale. We are including in Section II a number of recommendations relating to increased opportunities for older persons. In Section III we are emphasizing the need for a shift from institutional services to community-based care, and in Section IV we are looking at education in gerontology and geriatrics (medical education). This is an area of concern we have raised before because we feel that there is great need for those who are working with older persons, in particular health professionals, to have a good understanding of aging and the special needs of older persons.

Section V contains a report on the development of the program of grants-in-aid of research on aging. For several years we advocated the development of an Institute on Aging, which could stimulate both education and research. This could not be carried out due to the general downturn in the economy in Alberta and the need for restraint in government expenditures. Therefore, last year we recommended the development of a small fund for grants-in-aid of research on aging.

The Minister of Social Services and Community Health has responded favourably to this by allocating funding from the temporary grants program of the Senior Citizens Bureau, asking that it be administered under the guidance of a Subcommittee of this Council.

In conclusion, as a Council we feel that we have a responsibility to raise concerns and to try to improve the situation of older persons in Alberta. We appreciate the Government's response and the programs that have been developed for seniors. We want to emphasize, however, that the majority of older persons are self-sufficient and capable and that they have much to contribute to Alberta society, personally and economically. We find it unfortunate that so many people see the increasing numbers of seniors as a potential problem or a large disadvantaged group in need of protection, care or institutionalization. This is far from the truth. While we want to be sure that the minority in need of care and protection receive such help, we want to reinforce the concept that the great majority of senior citizens and their families are responsible, competent people, capable of solving their own problems and looking after themselves both financially and socially. What is required is the following

- involvement of seniors in the design and development of programs for their age group;
- programs that will enable seniors to continue their own self-care, as well as the provision of information about these and other programs and benefits;
- support services for those who require help on an intermittent or continuing basis.

Finally, we want to thank the Minister of Social Services and Community Health for the cooperation and support the Department has given the Council since its establishment in 1976.

Footnote

1. Canadian Medical Association, *Health, A Need for Redirection: A Task Force on the Allocation of Health Care Resources* (Ottawa: Print Action Limited, 1984).

SECTION I: RETIREMENT POLICY AND PENSIONS

Of paramount importance in ensuring health in the later years is a smooth transition to retirement and adequate income; both will assist older persons to begin this time of life with a positive attitude.

RETIREMENT POLICIES

At the present time, in many situations the retirement age is established arbitrarily by the policy of the employing body. It is usually 65 and represents an abrupt transition from work to leisure. Flexible retirement would make for a psychologically smoother transition and would give a chance to relate the retirement age to individual need and ability. It could, for example, take place any time between the ages 60 and 70. It could be a mutual arrangement between employee and employer. In addition to being psychologically satisfying, gradual retirement and work options would provide a way for some retired persons to increase their incomes. These work options would allow an employer to retain the services of an employee on a contractual or consulting basis. Part-time jobs and shared jobs would permit a different type of retirement. Appendix B, a paper prepared at the request of Council in 1979, contains a description of how both flexible and gradual retirement practices could work.

Such retirement policies have to be considered for the future not just because of their effects on the elderly but also because the number of new entrants into the labour force will decline in the next few decades. The ratio of young Canadians has dropped significantly since 1961. Today there are 55 young Canadians for every 100 aged 20 to 64. The ratio will continue to decrease to about 44 in 2011 and then remain in the mid-forty range until the mid-century. At the same time that this future source of the work force is becoming smaller, the number of retired elderly will increase. From the present ratio of 17 Canadians 65 or over for every 100 of working age, the ratio will grow to 22 seniors for every 100 persons age 20 to 64 in 2011 and will escalate to 36 for every 100 persons of working age by 2031.[1]

Shorter hours or redesigned jobs would allow some of these older persons to become an experienced pool of employees whose expertise could be used until they reach a maximum age limit, perhaps age 70. This experience would be of great benefit to the employer. Such flexible retirement would depend on the health and desire of the employee and the need of the employer.

According to the 1979 Harris poll of U.S. citizens, the majority of respondents indicated they would be willing to work beyond retirement age if flexible work options were available.[2] Flexible retirement would also assist in meeting the costs of an ever-increasing segment of retired persons and would create a counter-balance for the trend towards early retirement. It seems to be a better alternative than delaying the mandatory retirement age required by employers from 65 to 70 and gradually raising the age of eligibility for benefits as the United States government has done.

TO THE MINISTERS OF LABOUR AND MANPOWER

RECOMMENDATION ONE: FLEXIBLE RETIREMENT PRACTICES AND WORK OPTIONS

The Council recommends that the Departments encourage the development of more flexible retirement practices such as extending the retirement age and work options through part-time, contractual and relief work. This could be encouraged through mutual agreement between employer and employee.

PENSIONS

A further difficulty faced in retirement is a financial one. Government income security programs and private pension plans still do not provide an adequate income for all elderly Canadians, notably the large and growing group of the single aged (mostly women). The Federal Old Age Security (OAS) and Guaranteed Income Supplement (GIS) programs as well as the Alberta Assured Income Plan (AAIP) try to address the anti-poverty objective of the Canadian retirement income system. All Canadians 65 and older receive OAS and half of the elderly have incomes so low that they qualify for the GIS.[3] In Alberta, in December 1983, 47.2 percent of the pensioners receiving OAS qualified for some subsidy, and 11 percent received maximum GIS and provincial subsidy (AAIP). At present, in Canada as a whole, OAS and GIS are contributing one-third of the income of elderly Canadian couples and 40 percent of the income of single elderly persons.[4]

These retirees have to rely on OAS, GIS and AAIP because the second and third levels of the pension income system have not been adequately developed. The Canada Pension Plan makes up a second level of retirement income and private pension plans and retirement savings plans (the latter encouraged by tax deductions) form a third tier. Too many pensioners have to depend on income supplementation because the Canada Pension Plan is designed to replace only one-quarter of the pensionable earnings of an average wage and more than half the work force does not belong to a private pension plan.

Reforms in the regulations for private pensions and retirement savings have been suggested. The Federal Government took steps in this direction in the February 1984 budget when it announced tax concessions for those contributing to either private pension or retirement savings plans. By this arrangement a taxpayer could file each year an income tax deduction of 1 to 18 percent of career earnings to date, less previous pension and retirement savings contribution. A deduction of $1,000 on interest received from any pension plan or retirement savings plan is also allowable.[5]

The reforms outlined in our recommendations will improve retirement incomes overall but there will still be need for continuing increases in the Canada Pension Plan until Canadians receive an adequate retirement income. We believe it essential that in the future the public pension plans (CPP with OAS) provide, to the greatest extent possible, a basic minimum income for all seniors. Private plans and retirement savings would then supplement this basic income according to the preference of the individual.

For our recommendations on pensions, we are indebted to the Department of Labour and its discussion paper, *Proposals for Improving the Private Pension Plan System in Alberta*, May 1, 1984. We reviewed the paper, are in support of the vast majority of the proposals presented, and endorse some of them in the following recommendations.

The present lack of indexing in many plans causes a great hardship for those pensioners who retired a number of years ago and who have seen no change in the actual cash amount of their pension income but great increases in the cost of living. The Government should encourage indexing of all private pension plans.

Apart from financial considerations, another reason a great number of small businesses do not carry pension plans is a lack of interest and knowledge about them. Furthermore, self-employed persons do not have to be involved in the public plan, and so may retire with little or no income.

TO THE MINISTERS OF FEDERAL AND INTERGOVERNMENTAL AFFAIRS, LABOUR AND SOCIAL SERVICES AND COMMUNITY HEALTH AND TO THE PROVINCIAL TREASURER

RECOMMENDATION TWO: CANADA PENSION PLAN

The Council recommends that the Government of Alberta support an expansion of the Canada Pension Plan, that employee payments (1.8 percent of salary of the employee, up to an annual income of approximately $20,000) be increased gradually (half a percentage point per year) up to 4 percent a year for the employee and 4 percent a year for the employer, that the benefits paid to retired persons be increased (possibly doubled) over a period of time, and that self-employed persons be required to pay into the Canada Pension Plan.

TO THE MINISTER OF LABOUR AND THE PROVINCIAL TREASURER

RECOMMENDATION THREE: PRIVATE PENSION PLANS

The Council recommends

- that the Government encourage the expansion of indexed private pension plans through special appropriate tax incentive programs for the employer and through educational programs about the benefits of such plans;
- that where there is a private pension plan, all permanent full-time and part-time employees be required to participate;
- that vesting provisions (now mostly ten years) be relaxed, dropping to five years or less;
- that the portability of private pension benefits be improved by providing the option that the value of the terminating employee's benefits be transferred into an equivalent of a ''locked-in'' RRSP;
- that upon marriage breakdown the vested pension benefits be split equally between the spouses but remain as ''locked-in'' pension benefits until retirement;
- that employees be entitled to full information about the status of their pension plans and that annual statements showing the accrued benefits be available from all pension plans;
- that Government continue to regulate the investment of private pension plan funds;
- that married employees be required to choose a survivors' benefit option, providing that at least 60 percent of the original pension will continue should the retired employee die.

TO THE MINISTER OF LABOUR, AND THE PROVINCIAL TREASURER

RECOMMENDATION FOUR: RETIREMENT SAVINGS

The Council recommends that Registered Retirement Savings Plans and private pension plans be further encouraged through tax incentive measures in which the Government would ensure that the amount of funds so invested could be deducted from one's present taxable income (tax deferred until funds drawn out) with an appropriate upper limit set on the amount.

Footnotes

1. Government of Canada, *Pension Reform* (Ottawa: National Council of Welfare, 1984)
2. Garfield, E., "Social Gerontology, Part 2 Demography, the Effects of an Aging Population" in *Current Comments*, Vol. 27, No. 22 (May 28, 1984).
3. Government of Canada, *op. cit.*
4. Ibid.
5. Ibid.

SECTION II: OPPORTUNITIES AND THE PROMOTION OF GOOD HEALTH

The promotion of health involves the creation of a number of opportunities for retired persons, with the recognition that within that group there are many different kinds of individuals and a great variety of interests. What appeals to one will not appeal to another. Many will continue doing what they have always done, but we feel that there are opportunities/programs that could be supported by Government that would be enabling and encouraging for many.

SENIOR CITIZENS CENTRES

Since 1969 many senior centres have been established in the province through local initiative and with the support and encouragement of the federal New Horizons program, provincial and municipal Family and Community Support Services and grant programs from the Departments of Culture and Recreation and Parks. Ways are now needed to encourage centres to involve senior citizens as leaders and resource persons in the community. Centres should also be assisted in becoming self-help groups with mutual networks of support, sharing and advocacy. This last role would mean that centres could become an even greater help in maintaining morale which assists in preserving health. (The Department of Social Services and Community Health emphasized this in a 1975 Position Paper on Senior Citizens.)

The Alberta Council on Aging has received initial funding from New Horizons, for a project entitled the ACA Volunteer Community Consultant Project, to develop ways to recruit, train and support senior volunteers. These volunteers would provide consultation to senior centres and other community groups.

The project has had the support of the Senior Citizens Bureau (Alberta Social Services and Community Health), Alberta Recreation and Parks, Alberta Culture and New Horizons (Health and Welfare Canada). We would like to see these Departments continue their work with the Alberta Council on Aging in developing this corps of retired persons so the program will be coordinated and include the best available resources. As the project develops we see the need of some funding for a support staff for the volunteer consultants.

TO THE MINISTERS OF CULTURE, RECREATION AND PARKS AND SOCIAL SERVICES AND COMMUNITY HEALTH

RECOMMENDATION FIVE: VOLUNTARY COMMUNITY CONSULTANTS

The Council recommends that the Departments work with the Alberta Council on Aging and the federal New Horizons program to develop a corps of retired persons to work as consultants to organized senior centres, developing senior centres and other senior groups.

PHYSICAL FITNESS

Persons of all ages need time for recreation/leisure. Many of the present generations of older people have placed little emphasis on this or on physical fitness. However, we feel that their encouragement to do so through information/education and the development of appropriate programs would help seniors achieve better health. Good health habits should also be developed in the years before retirement. In fact, as much emphasis should be put on this as there is in achieving financial independence for the retirement years. The 1982 national conference, "Fitness and the Third Age," brought out the importance of regular and appropriate physical activity for continuing physical and mental health.

The Council appreciates the work that is being done - the funding by Recreation and Parks of the Senior Games and of the Alberta Senior Citizens Sport and Recreation Association, and the efforts of Department consultants to stimulate recreation services provided by municipalities to include seniors as clients. Efforts have also been made by the federal government to encourage exercise through its Participaction Programs. However, we would like to see an increase in the number of trained physical fitness instructors so more fitness programs can be provided either as special offerings of municipal recreation departments, as part of a regular program for persons of all ages, or in senior centres, lodges and nursing homes. It is important that these instructors not only be qualified but that they also consider how information about useful resources could be exchanged among instructors.

TO THE MINISTER OF RECREATION AND PARKS

RECOMMENDATION SIX: PHYSICAL FITNESS INSTRUCTORS

The Council recommends that more physical fitness instructors be trained to work with the general public at all age levels, including seniors, and with elderly persons living in lodges and nursing homes, and that local recreation boards be encouraged to include senior citizen representatives.

EDUCATION ABOUT AGING AND THE LATER YEARS AND LEARNING OPPORTUNITIES FOR SENIORS

There are two aspects of learning opportunities to be considered: the increasing of the awareness of what happens to people as they age and the provision of educational opportunities for the retired person.

Educational opportunities for retired persons are important. There are already numerous opportunities for further education, many of them funded through the Further Education Branch of the Department of Advanced Education. These opportunities are appreciated because retirement gives people leisure time to pursue a variety of educational programs, which can result in stimulation, meaningful and creative work and social contact.

Education about aging would help people, particularly young people, but older people as well, understand that growing old does not mean one becomes "senile" or "sick"! While we are not denying the physical changes that do develop, senility and sickness are not part of normal aging.

Education about aging should be undertaken so that our behavior towards older people and towards our own aging can have a more realistic basis. It should begin at an early age, in elementary schools, and continue into programs such as those for retirement planning. By using active older persons in school programs about aging or other topics of interest (an example is the Heritage program of the Society for the Retired and Semi-Retired in Edmonton), young children can have contact with persons who demonstrate that to be old does not mean being sick or senile. Appendix C includes units on aging that have been presented to the Separate School office in Calgary. These units are an example of educational materials that can be used or further developed.

TO THE MINISTER OF EDUCATION

RECOMMENDATION SEVEN: EDUCATION ABOUT AGING

The Council recommends that the pilot project presented to the Calgary Separate School system described in Appendix C be evaluated by the Department and, if it is assessed worthwhile, it or similar material be incorporated into the curriculum options on a province-wide basis.

HEALTH PROMOTION

As we have pointed out, the promotion of health is dependent on many factors other than traditional health services. Local Health Authorities (Local Boards of Health and Health Units), whose primary purpose is preventive health, can play an important role in maintaining the health of older people. Community Health Nurses have provided excellent service in maternal and child health care, and we are convinced these nurses could also help seniors to keep themselves in better health and prevent disabling conditions to some extent through self-care.

This could be done by helping older people develop healthier lifestyles. For example, they could learn more about exercise, about handling grief and stress, about sound nutrition and about health hazards (use of drugs, accident prevention). Individual and group counselling/information sessions in homes, senior and community centres and senior apartment buildings would be an effective way of doing this. Immunization for influenza and health screening for chronic conditions (diabetes, high blood pressure) could be offered not only at health unit offices but in other places where seniors meet. Early detection of disease could result in early referral for treatment. Nurses could help an older person understand, adjust to and stabilize a chronic disease which could prevent severe problems from developing. The growth of such programs would prevent problems and result in earlier intervention and treatment.

"Well-senior clinics" have been suggested. These could be held at scheduled times in various centres and provide the services mentioned above.

The mandate for such a role already exists but since local Health Units determine their own priorities, their work with seniors varies greatly. Across Alberta the time spent by Community Health Nurses in direct services to seniors varies a great deal, with many Units spending little time with persons over age 65 (7 to 8 percent in all of Alberta). Perhaps this imbalance could be improved if Community Health Nurses worked with groups of volunteer nurses (retired) in serving the elderly as is already being done in two instances in the province.

We would also like to see the Department of Social Services and Community Health sponsor two mobile health care vans, one for the northern areas and one for the southern areas, that would be available to all Health Units in the province. These vans could travel to senior residences, senior centres and senior groups and would carry materials that would develop the holistic, preventive and self-care aspects of health. Such ideas are not new. In 1975 an International Symposium on "The Role of the Individual in Primary Health Control" was held in Denmark. In 1974 a federal report, "A New Perspective on the Health of Canadians," stated,

> *The Government of Canada now intends to give human biology, the environment and lifestyle as much attention as it has to the financing of health care organization so that all four avenues to improved health care are pursued with equal vigor.*[2]

Meanwhile, physicians themselves have become promotors of self-care, initiating innovative projects and advising on others as well as encouraging their patients to practice healthier habits. A few professional schools (the University of Alberta Faculty of Nursing, for example) have altered their curricula to incorporate self-care. With the current financial pressures, it would seem wise for provincial governments to begin adopting self-care as an economic strategy, since many visits to doctors and hospitals could be avoided as people are educated to care more about and for themselves. (Appendix D explains how the vans could be used and what they might contain.)

TO THE MINISTER OF SOCIAL SERVICES AND COMMUNITY *HEALTH*

RECOMMENDATION EIGHT: MOBILE HEALTH CARE VANS

The Council recommends that the Department sponsor two mobile health care vans that would be accompanied throughout the province by a Community Health Nurse, would contain materials on the holistic, preventive and self-care aspects of health and would be made available to senior residences, lodges, senior centres, and senior groups.

HOUSING

Alberta has provided many programs to help seniors stay in their own homes and others that allow those on low incomes to live in subsidized housing. However, until now little assistance has been given to middle-income seniors to help those who are interested in the design of suitable retirement living complexes.

Research and extensive surveys, some sponsored by the Department of Housing, have led to plans for detached homes for people aged 50 or more who are not on low incomes. These plans, done jointly by an architect and builder in Calgary, include both individual and groups of houses (carefully designed single-storey homes) that require less expense and effort to maintain and allow their owners to enjoy gardening and outside activities.

All the homes, whether basic or luxurious, share special design features. The planners have eliminated most of the stretching and bending that is usually involved in a home. Bathrooms are designed so that they may be fitted with support bars if necessary. Level and well-lit entrances provide both convenience and security. For additional protection, houses that are grouped together may be connected by an intercom system.

These and many other features are integrated into the house design so that as the owners grow older, they will not be inconvenienced and need to move. We are hopeful that these plans will not just remain on paper, and we would encourage the Department of Housing to support with low interest loans the building of some of these units as demonstration homes.[4]

ENRICHED HOUSING

Consideration should also be given to providing greater management oversight and services in some apartment complexes so seniors who are frail could continue living independently. A plan followed in some parts of Canada includes a design that incorporates self-contained apartments with assisted care for those needing more support. This plan would not require the construction of new buildings.

Senior residences with a high vacancy rate should be allowed to consider renovations that would permit them to offer a day care area where care for disabled elderly persons may be given on a day basis to include medication, meals, recreation, rest and a bath if necessary (see Section III, Day Programs).

In all these different approaches to housing, management personnel or support staff must be available to residents in time of stress or need.

TO THE MINISTER OF HOUSING

RECOMMENDATION NINE: HOUSING FOR SENIORS

The Council recommends that the Department continue its support of specially-designed homes for older persons who are in the middle income brackets and that consideration be given to developing more support staff in some already existing seniors' apartments.

INFORMATION DISSEMINATION

We have been concerned about the need for information dissemination - from information about benefits to information dealing with health maintenance. We see that this could be accomplished through Recommendation Five which supports the Alberta Council on Aging's project to provide trained senior volunteers as consultants to senior centres and the community and by Recommendation Eight which proposes mobile health care vans to make available materials and information about the preventive and self-care aspects of health.

MEANINGFUL ROLES FOR OLDER PERSONS

A speaker at the Alberta Symposium on Aging[4] indicated that the major goal in keeping older persons as a vital part of society is to assure them that life in old age has meaning. Much of this is up to the individual, but the community can help as well. Many opportunities for volunteer work exist at the policy and at the service levels in a variety of social, recreational, educational, religious, cultural, ethnic, organizational and service fields.

Opportunities for retired persons who may want paid employment should be encouraged for the small number desiring it. Government should take the lead in using interested retired employees in contract or part-time relief positions (see the section on retirement policies). Senior centres could be given small grants to operate retirement registries to help older persons find volunteer or paid occupations. The Society for the Retired and Semi-Retired in Edmonton has such a service started with a small grant from the Senior Citizens Bureau.

We all want to have meaning in our lives; we all want to feel needed and respected. Age does not change these needs. All members of society, seniors and others, must work together to ensure that these needs are met for as many as possible.

Footnotes

1. Stephens, Brian, "Attitudes Toward Aging, Old Age and Older Persons: A Review and Discussion" (Edmonton: Senior Citizens Bureau, Alberta Social Services and Community Health, 1978).
2. Lalonde, Marc, *A New Perspective on the Health of Canadians* (Ottawa: Information Canada, 1974).
3. Cragg, Geoff, "New Home Alternatives for People Over 50," *Foresight* (Edmonton: Alberta Council on Aging, Summer, 1984).
4. Provincial Senior Citizens Advisory Council, *Alberta Symposium on Aging - 1982, Guidelines for the Future* (Edmonton: Alberta Social Services and Community Health, May 1983).

SECTION III: THE NEED FOR SUPPORTS

There will always be some people who develop debilitating conditions and for those who live to a very old age there will be some need for help. To meet these situations, some support and care may become necessary for 15 to 20 percent of the older population. Much of this can be, and is, provided by family and friends. In other instances, organized help will be needed to supplement or replace this informal help.

It is how this support and care is provided that is crucial. The majority of seniors want to be as independent as possible, while also having the security of knowing that help is available as needed. Of these two, independence is especially important to a senior. This is often the reason why some resist asking for help because, while they would have more security and care, it might mean a loss of decision-making and privacy.

Many elderly people turn to their families for help.[1] Since families have varying capacities for helping, we need to find flexible ways of responding to the requirements of the individual family.

Among the needed services are:

EMERGENCY ALARM SYSTEMS

Modern technology is being used in some Alberta towns to provide a community-based alarm system that is attached to the individual's home phone. There are a variety of systems available. Generally, the system is activated by touching a small, wireless button clipped to clothing or carried in a pocket which activates a unit attached to the phone which automatically dials the hospital.

Most systems have another important feature, a timer which automatically starts the emergency response if the phone has not been used over a twenty-four hour period. Doctors who have patients in areas where these systems have been installed have found that blood pressure and heart conditions improve because of the feeling of security. This system also eases family tension and anxiety.

It is Council's hope that more communities and individuals will see this as a viable way of assisting the elderly and handicapped.

COMPREHENSIVE HOME CARE

Council has been encouraged by the extra funding given to the Coordinated Home Care Program and feels that such a program should have the capacity to link a variety of services. It should be the initial point of contact for persons in need of care, provide screening and assessment, arrange for appropriate services and stay in contact with the client to ensure that these services are provided as needed. In other words, Home Care should provide the coordinating "case management" function, contacting, as needed, such services as friendly visiting, escort and shopping help, and daily telephoning groups as well as providing, as needed, the main home care services.

A few older persons do need a protective service. These are individuals who may be living alone, have few family and friendship supports and need some ongoing assistance due to periods of mild confusion and general frailty. They may need regular contact with someone who would

visit them, help them with practical matters and ensure that all is well or link them with professional help if it is needed. This type of support can be provided, and usually is being provided by volunteers and staff connected with senior centres and by Family and Community Support Services outreach workers. It seems to us that the development and direction of this work should be supported by Home Care and be included by them in the services available to meet the assessed needs of these older people. This role should develop as Home Care increases expertise in assessment.

The Home Care Nurse is indispensable in identifying persons who are at risk of developing serious health problems and linking them quickly with appropriate medical help or home care. By helping these people reach diagnostic help and treatment quickly, the nurse may prevent serious and permanent mental or physical disability.

Since the Coordinated Home Care Program is caring for ever-increasing numbers and developing as an important assessment and coordinating group (see discussion on "single point of entry to long-term care"), it seems to Council that it might be wise to initiate discussion about Home Care having greater autonomy in making decisions about its program and operation. At the present time the Home Care Advisory Committee is just that - an advisory group, with the Health Unit Board being accountable to the Minister for the expenditure of funds for Home Care and being the ulitmate authority for all aspects of the Home Care program and operation. Under the new Public Heath Act these Advisory Committees will now be optional, and their development will depend on the interest of the Health Unit Board.

We feel that discussions should be held about the role of Home Care within the Health Unit. In general it seems to us that the major interest and focus of Health Unit Boards is "prevention," for example, preventing the spread of communicable diseases, maintaining sanitary conditions, and ensuring good maternal and child health.

This seems to us to be a very different function than that of Home Care, which is providing "hands-on" health and support services. We hope that these concerns will encourage the Department of Social Services and Community Health to re-evaluate the combined administration of these programs.

TO THE MINISTER OF SOCIAL SERVICES AND COMMUNITY HEALTH

RECOMMENDATION TEN: ADMINISTRATION OF THE COORDINATED HOME CARE PROGRAM

The Council recommends that a study be undertaken to look at the advisability of separating two very different types of delivery of health programs (Community Health and Home Care) now under one administration, the Health Unit Board.

DAY CARE FOR THE ELDERLY AND HANDICAPPED

This is a needed service for a few elderly and handicapped persons who are so frail and disabled (mentally and/or physically) that they cannot be alone for long periods of time or cannot use the services of a senior centre even if assisted with transportation. In day care, transportation is provided to bring them to a centre for one or more days a week. Here they receive therapeutic recreation, a meal, personal care (such as footcare, help with toileting and bathing), rest and general supervision and may participate in a social program.

Such programs are of great assistance to family care givers who need a period of rest and relaxation or have to work part-time. Experience with this program in Edmonton, now in its fourth year as a pilot program, and in other provinces shows that day care is an important service in helping families continue to cope and that in some instances it can delay or prevent institutionalization.

TO THE MINISTERS OF HOSPITALS AND MEDICAL CARE AND SOCIAL SERVICES AND COMMUNITY HEALTH

RECOMMENDATION ELEVEN: ADULT DAY CARE

The Council recommends that the Departments plan the scope, funding, delivery and evaluation of two or three more pilot day care programs for the frail and handicapped elderly in locations other than Edmonton.

DAY HOSPITALS

Day hospitals provide assessment, short-term treatment and rehabilitation therapy on an out-patient day basis to persons with a variety of disabilities. They are important, particularly in aiding persons discharged from acute care hospitals and those with strokes and broken bones who need rehabilitation. Day hospitals differ from day care in that they have a nurse, therapist and social worker on staff and have a doctor available and their goal is rehabilitation rather than maintenance. They are usually attached to auxiliary hospitals so the staff can be shared. Alberta now has five day hospitals in Edmonton and Calgary. Council hopes that day hospital services, perhaps connected with day care, will be available in the future in Lethbridge, Medicine Hat, Red Deer and Grande Prairie.

LODGES

We are encouraged to see that the Alberta Senior Citizens' Homes Association has developed standards for lodges, and that an educational program on the needs of older persons is being developed for resident supervisors. We agree these standards should be implemented and that a committee should be appointed by the Government with representation from the Alberta Senior Citizens' Homes Association and from the Alberta Mortgage and Housing Corporation to see that these standards are maintained. A summary of these standards forms Appendix E.

Such supervision is important since Alberta's 127 lodges are housing close to 7,000 older persons. It is essential that lodges follow the standards outlined in their new policy manual. The Alberta Senior Citizens' Homes Association is to be commended for undertaking their policy development study. However, we feel that there is room for further change in the policies concerning the clientele that the lodges will serve. Their policy manual states clearly that their objective is: "to assist and co-ordinate the provision of personal and health care services to the residents, maintaining their health and independence through preventative personal care."[2]

With increasing concern being expressed throughout the province about the need for multi-level care facilities and the desire to deliver varying levels of health care to the recipient instead of bringing the recipient to the appropriate level, we think it important that lodges consider developing extra services, including greater use of Home Care personnel, and in some cases providing more personal care and support. This would allow lodge residents who are becoming quite frail to continue living in familiar surroundings that they consider home. Perhaps special wings could be set aside in some lodges to provide these services or extra care could be made available to the resident in his/her room. Such a plan would also encourage the use of available lodge space.

These developments would call for a changing role for lodges, but already lodges are offering more services than they previously did. Some are now starting a vacation relief program which allows elderly persons living with friends or family to come to the lodge for a temporary stay. Services such as providing meals and social activities for those living alone are another development in the lodge program. We also see lodges with vacancies as possible sites for day care programs for elderly who cannot be left alone at home. All of these changes allow for the lodge to have an expanded role in promoting even greater health care while continuing to provide the support which it has done so well in the past.

TO THE MINISTER OF HOUSING

RECOMMENDATION TWELVE: STANDARDS FOR LODGES

The Council recommends that the Minister appoint a committee, which would include representatives from the Alberta Senior Citizens' Homes Association and the Alberta Mortgage and Housing Corporation, to oversee the implementation of the lodge standards.

NURSING HOMES AND AUXILIARY HOSPITALS

We are pleased with the Report of the Nursing Home Review Panel and that, with the establishment of the Interdepartmental Committee on Long Term Care and the Nursing Home Liaison Committee, the Department of Hospitals and Medical Care is taking steps to improve the care provided in our facilities. We would hope that in time, as the Panel report recommended, we will not have two separate types of facilities but that all will become multi-level care facilities. *As we have said in earlier reports (in particular in 1981), we need a new approach where the elderly person is not moved if his care needs change; rather, the package of care delivered to him is adjusted appropriately.*

If a long-term care facility could offer varying levels of care, this would mean that an older person would not have to move away from his home community and that husbands and wives would not have to be separated because they need different levels of care.

We have a real concern about the often inadequate diagnosis and care of mentally disturbed elderly in nursing homes and auxiliary hospitals. The Nursing Home Review Panel and the Provincial Mental Health Advisory Council reports both recommended that aggressive and abusive residents should be segregated from mentally well residents. The Review Panel suggested such residents be accommodated in specific sections of existing nursing homes or in an existing nursing home converted for such care while the Mental Health Advisory Council felt that they could be cared for in a specially designed unit which would preferably be part of or attached to and administered by a general or an auxiliary hospital or a nursing home. Both studies suggested the development of group homes as an additional way of caring for some mentally disturbed older persons in their own communities.[3]

For such changes to be effective an adequate diagnostic process needs to determine the correct diagnosis, treatment and plan of care for the mentally disturbed elderly. The addition of a person trained in psychogeriatric evaluation in the assessment/placement model (See Appendix F) would help to provide the proper physical, mental and social assessment.

In the case of the mentally disturbed who are already in nursing homes, their assessment should be reviewed every six months to see that proper treatment, rehabilitation and maintenance are being provided. To do this, the above professional connected with the assessment/placement service or a mental health professional with proven expertise in the area of gerontology attached to Alberta Mental Health Services or to a general hospital needs to be given responsibility for a number of nursing homes in a geographic region.[4]

We support the programs for upgrading the skills of staff in nursing homes and auxiliary hospitals to enable them to respond effectively to the special needs of the elderly and mentally disturbed.

We believe these changes would allow mentally disturbed elderly persons to be cared for in their own communities without causing harm or fear to those elderly persons who are mentally well. These changes would not result in the neglect of mentally disturbed older persons as there would be services provided to them

TO THE MINISTER OF HOSPITALS AND MEDICAL CARE

RECOMMENDATION THIRTEEN: PSYCHOGERIATRIC CARE

Council endorses the recommendation of the Provincial Mental Health Advisory Council that only patients suitable for nursing home care should be admitted to or maintained in regular nursing homes. Some nursing homes and auxiliary hospitals interested in having special units for mentally disturbed older persons should be funded to develop specific programs for these patients.

CHARGES FOR LODGES, NURSING HOMES AND AUXILIARY HOSPITALS

At the present time it actually costs an older person more to stay in a lodge than it does for him to stay in a nursing home or an auxiliary hospital, although the latter two facilities provide more care. In fact the first 120 days of stay in an auxiliary hospital, the facility providing the greatest degree of care, are free. There is, therefore, a financial incentive for persons to seek higher levels of care (care that is more costly to the public purse).

TO THE MINISTER OF HOSPITALS AND MEDICAL CARE AND THE MINISTER OF HOUSING

RECOMMENDATION FOURTEEN: CHARGES FOR LODGES, NURSING HOMES AND AUXILIARY HOSPITALS

The Council recommends that residents in continuing care facilities pay the cost of their room and board, that the room and board charges for all three facilities (lodges, nursing homes and auxiliary hospitals) be the same and that the 120 initial free days in an auxiliary hospital be removed (persons should start paying when admitted), if and when the auxiliary hospital is designated as the permanent residence of the individual.

SINGLE POINT OF ENTRY TO LONG-TERM CARE SERVICES

We support the steps being taken to develop and pilot a model for a single point of entry (a coordinated assessment and placement service) for all long-term care services - home care, day care and day hospitals, lodges, nursing homes, auxiliary hospitals. We believe that it is essential that entry into these services be coordinated and that the first (and single) point of entry be through the Coordinated Home Care Program. Before a decision is made to place a person in a long-term care facility it should be ascertained that he really cannot manage in a less costly and more "independent" setting with the help of home care and other community services.

We did have some concerns about the model which was circulated in the report dated April 4, 1984 and prepared a short paper presenting our ideas as to how an assessment/placement model should be structured. We would like to see a model piloted in one urban and two rural areas (one north, one south). This paper was sent to the Minister of Hospitals and Medical Care, through the Minister of Social Services and Community Health, and a copy of it forms Appendix F.

It should be mentioned that while the majority of us felt that admission to lodges should be through the one assessment/placement service, some members disagreed, feeling lodges should control their own admissions. It was felt by the majority that since lodges are caring for increasingly dependent older persons, their applicants should have the advantage of being screened through the single entry point to determine the level of care needed. Lodges are an important part of the network of care for older persons. If lodges do not become part of the total continuum of care, this will be to the disadvantage of the older people in Alberta.

We are also pleased with the steps being taken by the Department of Social Services and Community Health, with the cooperation of other departments, to develop a comprehensive assessment tool. This is an absolute necessity. At the present time everyone is "assessing" the elderly - from community outreach workers to the Public Guardian's Office - often not just once, but several times. Different approaches are used, and often the "assessment" involves only one discipline and one approach. Decisions are often made on the basis of little information and are made *for*, not *with*, the older person and his family. In fact often the older person and his family are not even involved in the decision and no attempt is made to ascertain their wishes and ability to help. This multiplicity of approaches is not only confusing to the public, it is wasteful of public money and results in inappropriate placements.

Footnotes

1. Department of Health and Social Services, Social Services Branch, Special Services Division, *Towards Meeting the Needs of Senior Citizens in Prince Edward Island* (Prince Edward Island: 1981).

   Saskatchewan Senior Citizens' Provincial Council, *Regina Social Support Study* (1981).

   Blair, D., "Use of Formal and Informal Support Resources by Elderly in a Rural Community," A Thesis Submitted to the Faculty of Graduate Studies in Partial Fulfillment of the Requirements for the degree of Master of Science, Department of Medical Science. (Calgary, Alberta: The University of Calgary, September 1981).

2. Proposed Standards for the Alberta Senior Citizens' Homes Association.

3. Alberta Hospitals and Medical Care. *Report and Recommendations, Alberta Nursing Home Review Panel* (March 1982).

   Provincial Mental Health Advisory Council, *The Optimal Use of Nursing Homes in the Care of the Mentally Disturbed Person* (Edmonton: Alberta Hospitals and Medical Care, June 1980).

4. Provincial Mental Health Advisory Council, *op. cit.*

SECTION IV: EDUCATION IN GERONTOLOGY AND GERIATRICS

EDUCATION IN GERONTOLOGY

The Council has noted with pleasure the growing interest of younger Albertans in acquiring knowledge about aging processes and possible ways of improving the quality of life of senior citizens. One sign of these concerns was an enrolment of well over 1,000 students in gerontology courses offered in the three full-time provincial universities during the 1983-84 academic year. These courses are also popular among mature students returning to academic life after spending years in the labour force or as homemakers. In addition, there are about a dozen graduate students at Alberta universities whose research theses center on gerontological topics.

Clearly, the universities and their faculty members are to be commended for their efforts in the area at a time when increasing numbers of students in traditional disciplines are making great demands on restricted budgets. Nevertheless, the demand for educational opportunities in aging spheres exceeds the supply, as is evidenced by some Alberta students moving to other provinces and countries to achieve their educational goals. The Minister of Social Services and Community Health has shown that he realizes the deficiencies by stating in his response to the Council's 1983 report: "...but I recognize the need to have greater undergraduate and graduate professional curriculum content in geriatrics and gerontology." Alberta will require more and more individuals with varying levels of qualifications to serve its future elderly population.

The Council has chosen education as one of its foci of attention during 1985. We are aware that the Universities of Alberta and Calgary and some of the junior colleges have aready begun to formulate long-term plans for offering certificates or specialized graduate degrees in gerontology. There are also some more immediate projects for designating aging as an area of concentration for undergraduate degrees. However, our impression is that the independent institutions in our Province have given insufficient consideration to coordinating their efforts so that the best possible use of resources is made. Such coordination becomes especially expedient, now that an Alberta Institute on Aging is unlikely to materialize in the near future. Coordination should have as its main aim the sharing of expertise. Facilitating the exchange of students among institutions and establishing jointly sponsored summer schools are obvious possible strategies for fulfilling that aim. There are also some very sensitive issues concerning qualifications of instructors and graduate supervisors in a newly established area of study, where recognized credentials have not been formalized. The question of immersion-type advanced courses for existing and prospective teachers deserves attention. Such workshops should, in the main, be staffed by Alberta's own experts, rather than by importing prophets from other countries.

Decisions on these and other cognate matters must be made by the institutions themselves. The only step that the Council would suggest at this stage is that a symposium be held during 1985, with representation from all interested Alberta institutions of post-secondary education to discuss ways of coordinating efforts in, and formulating future plans for, gerontological education. It may well be that such a conference would lead to identifying specific deficiencies in existing resources and a request to the Government for approving special funds for advanced training in the area.

TO THE MINISTER OF SOCIAL SERVICES AND COMMUNITY HEALTH

RECOMMENDATION FIFTEEN: EDUCATION IN GERONTOLOGY

The Council recommends that an appropriate grant be made available to underwrite the costs of a conference to discuss the coordination of plans for education in gerontology.

GERIATRIC EDUCATION AND SERVICES

A proposed program in geriatrics at the University of Calgary was briefly mentioned in last year's Report, in which we recommended that the three relevant government departments (Advanced Education, Hospitals and Medical Care, Social Services and Community Health) encourage and support such a development. This matter has continued to be a major concern of the Council during 1984, not only from the perspective of health needs of future elderly generations. Just as important will be the immediate effect of the presence of teachers of geriatrics attached to the University in overcoming the major deficiency in the provision of health services available to today's older population in Calgary and Southern Alberta. The reciprocal relationships between the quality of health services and geriatric education cannot be overemphasized. At present, there is not a single officially accredited geriatric specialist available to frail and sick elderly patients in Southern Alberta and experienced geriatricians will not be attracted there without a university base.

Once there are university-based geriatricians, they will establish facilities and delivery systems to serve as models for their students and will also practice in the community-at-large. Thus, a program in geriatrics at the University of Calgary is a necessary precondition for fulfillment of the Council's aims to improve the quality of care and cure, as well as prevention of illness among the elderly.

Although geriatricians, especially teachers of geriatrics, need to have some hospital beds available to them, the Council hopes that there will be a geriatrician in this program who will concentrate on observing patients in their usual surroundings and, in consultation with relatives and professionals who have previously provided service to the patients, will develop a program of care using professional and voluntary home services. Only a small proportion of elderly with limitations in their living activities really require the costly transfer to institutions - costly in respect to finances as well as quality of living. Even Alzheimer patients, at least in the early stages, are frequently able to remain in their own homes provided respite is available for the 24 hour-a-day care giver. The presence of a geriatrician in the community should avoid increasing the demand for acute care beds in general hospitals and long-term care in auxiliary hospitals.

The Council has been informed of the steps taken at the University by the Faculty of Medicine and the Task Force on Geriatric Medicine with respect to future geriatric education. The Task Force has completed a preliminary report that recommends a focussed and limited thrust in two stages, with the initial stage being put in place during the coming two years and the following stage during the successive three years. The initial stage would utilize existing resources and those that could be made immediately available at Foothills Hospital. This would include a small geriatric observation and assessment unit of 6-12 beds, which would immediately result in medical students having some focussed clinical training in geriatrics. The following stage would involve the recruitment of three to five geriatric specialists, but there is no intent to embark on a new building program as was done in Edmonton. Although the Edmonton Youville model will not be duplicated in Calgary, Foothills Hospital and the University have benefitted from that example.

The Council views the steps taken so far in Calgary as praiseworthy, and appreciates some of the complexities in planning a new venture of this kind and in bringing plans to fruition. Nevertheless, we are concerned at the slow pace at which future developments are likely to occur.

There seem to be two interconnected major obstacles that prevent the acceleration that we would like to see. First, there is the need to consult with, coordinate, and obtain approval from a variety of networks of committees, lines of administrative authority, governing boards and departments of government, each with separate constituencies. Secondly, tightening of budgets over recent years leaves no money to spare.

The Council considers that the only way to ensure that a viable geriatric education group of the quality desired will be established with dispatch is through a special grant. The size of the grant must be sufficient to establish a Chair of Geriatrics at the University of Calgary, and for the appointment of one additional faculty member, one psychologist and the necessary secretarial assistance. Salaries of future members of the geriatric team would, to a considerable extent, be covered through clinical practice in the community and joint appointments with hospitals. Research monies should also become available once the senior appointment is made and a fund-raising drive would then also be feasible. (Appendix G is a background paper that explains this in more detail.)

TO THE MINISTERS OF ADVANCED EDUCATION, HOSPITALS AND MEDICAL CARE AND SOCIAL SERVICES AND COMMUNITY HEALTH

RECOMMENDATION SIXTEEN: EDUCATION IN GERIATRICS

The Council recommends that an appropriate annual grant be made to the University of Calgary for an initial period of seven years to permit the establishment of a Chair of Geriatrics, the appointment of one additional faculty member, one pyschologist and the necessary secretarial services.

SECTION V: GRANTS-IN-AID OF RESEARCH ON AGING

The Provincial Senior Citizens Advisory Council has been attempting to promote research activities on aging for the last six years. In the 1983 annual report we recommended

- that the Government of Alberta support incentives to promote research on aging;
- that the Minister of Social Services and Community Health establish a separate fund for research on aging;
- that the Minister establish a Subcommittee of the Provincial Senior Citizens Advisory Council to administer the research fund.

We did so because we were, and still are, convinced that research specific to aging is imperative to improve and maintain the well-being of the elderly and to ensure appropriate utilization of resources.

We are pleased that in May of this year (1984) the Honourable Neil Webber, Minister of Social Services and Community Health, approved the use of some of the unallocated grant funds of the Senior Citizens Bureau, specifically $100,000, for grants-in-aid of research on aging and asked that the program be carried out with our assistance. At his suggestion, we established a Research Subcommittee to oversee the program.

The Subcommittee is chaired by the Chairman of the Council and includes a senior official from the Department of Hospitals and Medical Care, a senior official from the Department of Advanced Education, the university representative on the Council and the Consultant from the Senior Citizens Bureau.

The purpose of the Research Subcommittee is to advise the Senior Citizens Bureau on the administration of the research funds.

Its responsibilities are

- to formulate annual guidelines for deciding on research funding;
- to review all applications for grants-in-aid of research on aging;
- to make recommendations to the Department of Social Services and Community Health regarding the funding;
- to assess the need for continued and expanded funding for research in Alberta.

One of the first tasks of the Research Subcommittee was to develop objectives, set priorities for the grants and establish eligibility criteria.

The objectives of the grants are

- to provide opportunities for Alberta researchers to contribute knowledge about aging and to share this knowledge with others in order to improve the well-being of older people;
- to encourage the development of research projects with practical implications for the lives of older persons;
- to increase public awareness about the importance of research in aging in view of the growing numbers of elderly individuals;

- to increase the opportunities for communicating research findings on aging.

Priority is to be given to research proposals relating to the social, psychological and environmental aspects of aging.

The eligibility criteria are

- Canadian citizen or landed immigrant;
- resident of Alberta;
- affiliated with or have an appointment in a health care, social service agency or educational institution.

A brochure and advertisement were developed with the assistance of Public Communications Services, Department of Social Services and Community Health. The grants program was advertised in all the major newspapers in Alberta, in post-secondary colleges and universities, and in the Senior Citizens Bureau Fact Sheet.

Consultations were held with personnel from other granting bodies, and a grants guide and application form were developed. A deadline of November 2, 1984 was set for receipt of proposals.

The Canadian Association on Gerontology assisted the Research Subcommittee in compiling a list of its members who have experience and interest in reviewing research proposals. Other potential reviewers were added to this list at the suggestion of members of the Subcommittee.

The initial response to the grants program has been good. Twenty-two research proposals in a range of subject areas have been received from a variety of organizations throughout the Province.

After initial screening by the Subcommittee, the proposals have been sent to independent reviewers with expertise in gerontology and research. The Subcommittee plans to be able to make recommendations to the Department early in 1985.

APPENDIX A

LIST OF BACKGROUND PAPERS ATTACHED TO REPORTS OF THE PROVINCIAL SENIOR CITIZENS ADVISORY COUNCIL, 1977-1983

1978

- Options for the Organization and Delivery of Services to Older Persons in Alberta
- Senior Centres in Alberta

1979

- Retirement Options: A Summary
- Problems with Existing Income Provisions: Affecting Federal Goverment Programs (a short statement)
- Towards an Effective System of Services for Semi-Dependent and Dependent Older Persons

1980

- Community Health and Social Services
- Statement on the Institute of Gerontology (a short statement)
- Statement on Preventive Social Services (a short statement)

1981

- Brief to the Nursing Home Review Panel

1982

- Comments on the Report of the Nursing Home Review Panel (a short statement)
- Human Rights and Older Persons
- Death, Dying and the Elderly
- Design for an Alberta Institute on Aging

1983

- Background Paper for a Research Fund on Aging
- Second Canadian Conference on Aging, Report Submitted to the Minister of Social Services and Community Health

In 1982, the Council sponsored the Alberta Symposium on Aging which was held in June of that year. A report on the Symposium was submitted to the Minister in September, and the Proceedings were published in 1983.

APPENDIX B

FLEXIBLE AND GRADUAL RETIREMENT POLICIES

From a paper by Brian Stephens, Ph. D., "Retirement Options: Alternatives and Issues." Presented to the First Annual Research in Aging Day, June 20, 1980, held at Kerby Centre, Calgary, Alberta and sponsored by the Alberta Council on Aging.

FLEXIBLE AND GRADUAL RETIREMENT POLICIES

Flexible Retirement refers to the "age" or timing of retirement. Full withdrawal still occurs at a specific age and date, but the actual age varies over a wide range. Thus, preferences of the employer to keep or retire certain numbers of workers are facilitated. Within the limitations of the needs of the employer, individuals may retire earlier or later. This provides some response to the desire to work longer (for whatever reason) or to retire early. Thus, flexible retirement approaches the problem of timing, that is, preferences for earlier or later retirement.

Gradual Retirement means that a person moves from full-time employment through decreasing amounts of work per year to full retirement. Within this concept it might still be possible for an individual to reach a state of only a few hours of work per week, which is retained thereafter, or to retire fully. Gradual retirement thus approaches both the problem of timing and the problem of abruptness.

Both of these variations still assume that for most individuals full retirement will occur and also that there is an upper age (in the cases presented, age 70) at which persons should stop working completely. Gradual retirement, however, allows for the possibility that an individual might maintain some form of job connection for the remainder of his or her life.

"Early" retirement, usually thought to be any age under 65, is a form of flexible retirement but could become part of a pattern of gradual retirement. Early retirement presupposes that the individual has specific objectives or specific reasons for taking this course. On the other hand, early retirement is also often utilized (and may only be available) because employers have reasons to change the composition of their labour forces. Under gradual or flexible retirement, employers could achieve the same result but still keep employees who were of particular value to them.

Flexible retirement age, because it retains the abruptness characteristic of retirement today, does not come to grips with the problems created by retirement as effectively as does gradual retirement. Although both gradual and flexible retirement can be facilitated by pre-retirement planning, increased post-retirement services, socialization and increased leisure and social opportunities, gradual retirement can make use of steady increase in non-work time to permit the individual to develop smoothly new daily patterns and new activities. The rate of withdrawal from the work force can be paced to the needs of the individual. Thus, even those who might prefer to work indefinitely have the opportunity to find new avenues of activity. There is no necessary reason why an individual who desired to work indefinitely could not replace work with one employer by finding alternative employment. Generally, though, we are considering that the basic pattern would involve less than full-time employment over a period of years. If we assume that aging will ultimately prevent full-time employment (even though this is not true of all), gradual retirement offers more likelihood of being tailored to individual requirements.

Both flexible and gradual retirement are compatible with job redesign and reassignment. These do not in themselves handle the problems of a sense of demotion or loss of status. Reassignment which is currently practiced with employees judged unsuitable before a mandatory retirement age has been reached, is particularly problematic. Under flexible retirement, reassignment might be foregone in favour of an earlier age of retirement. Under gradual retirement, reassignment with shorter hours might have the same effects as it now does on loss of status and sense of demotion.

Job redesign - adjusting the tasks of the job to changed capabilities - however, is compatible with both forms. Having one's job redesigned might involve some sense of lost status if it occured only with older employees. However, the benefits of job redesign are not confined to older employees. Younger employees (and job efficiency in general) may benefit also. Thus, job redesign could be viewed as a general policy rather than as a concession to older workers. In this way, problems of stigma and status would be overcome.

Retirement in Alberta found a strong level of support for gradual retirement and related modifications to retirement practices among both retired and pre-retired. Less than 14 percent of the sample rejected gradual retirement outright. On the other hand, 68 percent indicated direct support for the idea. This finding was true for all classes of occupations, with the strongest support coming from farming occupations (86.1 percent support) and the least coming from service industry occupations (66 percent support). The respondents thought for the most part that the employer ought to play the role of providing pre-retirement counselling and, more significantly, providing adequate pay and pensions.

Income after retirement or during the "retiring" phase would still require some changes. Under the flexible retirement age scheme, pension levels might be different depending on the age at which the employee retired. Clearly, for those retiring before age 65, a penalty would be experienced if the public pension system remained unchanged, since this employee would not yet be eligible for the public pension. Although various adjustments could be imagined, flexible retirement in itself does not approach the problem of low income. Thus, it would still be necessary to upgrade the public and private pension system.

Gradual retirement, in contrast, offers the possibility of slowly lowering wages in relation to declining hours of work while at the same time phasing in pension benefits. If the public segment of the pension system remained fixed at age 65, and an employee began gradual retirement at age 60, he or she could at age 65 be working part-time, receiving some wages, some private pension, and full public pension. Subsequently, over the next five years to age 70, his income would slowly decline as the wages component dropped out. However, this longer period of higher income might permit a greater level of savings. In general, although public pension (OAS) commitments would not change, private pension plans (and the C.P.P./Q.P.P.) might either cost less for the same benefit rate or at the same cost be provided at a higher level. Hence, income in retirement could be increased.

Footnote

1. Third Career Research Society, *Retirement in Alberta*, Volume I and II (Edmonton, 1976).

APPENDIX C

AGING IS FOR EVERYONE:
UNIT FOR JUNIOR HIGH ON GROWING OLD

Prepared by:

Sister Jean Golden, Calgary

Provincial Senior Citizens

Advisory Council Report, 1984

AGING IS FOR EVERYONE:
UNIT FOR JUNIOR HIGH ON GROWING OLD

Unit I

Basic Issue -

Aging is for everyone. Getting old is not a disease. It is a part of life, and almost everyone will experience it. Aging is simply part of the life cycle; the "essence" of the person tends to remain basically the same, despite his or her physical changes. You are the same person you were when you were a baby but you have grown and matured. When you become an older man or woman you will still be you but your physical structure and some of your emotions will be different, just as your physical structure and emotions are different from when you were a baby.

Audio-Visual Material -

Side I of the tape, "Ages and Stages in Music."

Also ask students to bring in their own baby pictures so they will have them for class today. The teacher should have his/her baby pictures too. Sometime before class these could be put on the bulletin board with names attached, or there could be a contest to see who recognizes the most baby pictures.

Discussion -

Discuss the developments from the person in the baby picture to what the student is today.

Assignment -

Have each student interview his or her grandparent or an older adult about the grandparent's age. Have them ask about his/her birth, childhood, what growing up was like then, dating, marriage, family, work up to the present. With this information, the student can develop a biography about the life of the older person, not longer than 8-10 pages. Pictures or drawings would make the story more interesting. These biographies can be displayed in the classroom or shared.

Unit II

Basic Issues -

Canadian families come from different cultures. Some cultures had a closer family life. Children in earlier societies were often expected to do farm chores. In these cultures the standard of living was different than ours, and what people did for a livelihood might be different too. Education, religion and the place of women and older people also varied in different cultures. All of these social factors helped to develop your grandparent or great-grandparent into the person he or she became in later life.

Audio-Visual Material -

Use the film, "Three Grandmothers," or the Development, Education and Action slides and tape, "Growing Old in China and Canada."

Discussion -

Follow the showing of the film or slides with a discussion of the differences in the three grandmothers (one Canadian, one African, one South American) or in the Canadian and Chinese elderly because of the differences in the cultures in which they grew up. Discuss: the standard of living, religion, education, the status of the grandmothers or elderly, and family life.

Assignment -

Ask each child to develop a short research presentation (3-4 pages) with audio-visual aids which explains what life was like in the country of origin of his/her grandparent. (Some might have to go back to great or great-great grandparent.) The presentation should cover some of the following: culture (music, dance, art, etc.); standard of living; what people did to make a living; situation of women; religion; education system; transportation and, when possible, some information on the status of older people.

These research presentations should be as concise as possible and provide some understanding of what it was like to live in that particular country. There should be some oral presentation at the end to share the information with the rest of the class. Children who have the same country in their backgrounds could work in pairs.

Unit III

Basic Issue -

Older people have the same basic needs as others. All too often, meeting physical needs is emphasized for older people. This is important but it is not enough. Other needs, such as being able to live securely and having a sense of self-worth, acceptance and recognition in our society, also have to be met.

Audio-Visual Material -

Development, Education, Action slides and tape, "In Our Own Home."

Some Statistics -

There are now over 2.1 million people over 65 in Canada. By the year 2000, the elderly will make up about 20 percent of the Canadian population. It is not possible to estimate what the percentage of elderly will be when the present students are over 65 because we don't know how many Canadians will be born between now and then, but it could be over 20 percent.

Statistics Canada estimates that 50 percent of those between the ages of 65 and 69 and 63 percent of those over 70 live in poverty. Approximately 6 percent of the elderly live in institutions - nursing homes or some other type of facility.

Discussion -

Discuss how the students would like to live when they are elderly. It would be advisable to invite one or two elderly people to discuss what it means to be elderly in today's world. If possible, one of them should be living on a below average income.

Assignment -

Have each student write a brief paper on how he/she would like to live when they are in the 70's or 80's. Have them attach a paper that tells what changes will have to be made in Cana-

dian society so they will be able to live as they would like. Have them consider such ideas as financial security, health care, housing, independence, nursing homes, protection from crime, human dignity, stereotyping, acceptance and recognition of the elderly by society, and attitudes toward the elderly that need to be changed. It probably would be wise to form groups to work on each topic; however, the "How I Would Like to Live" paper needs to be done individually. Conversations with the elderly may help students to understand some of the joys and problems of the elderly. Information and ideas can be shared with the rest of the class.

Note for the Teacher

In each Unit, leave three or four weeks between the introduction of the basic issue (including the audio-visual presentation and discussion) and the day when the students will present their reports so they have time for interviews and finding resource material.

Side 2 of the tape, "Ages and Stages in Music," has some songs about the elderly that you may wish to use.

(All of the audio-visual materials are available from an Inter-Generational Organization on Aging.)

Development, Education and Action
St. Paul's Centre at Trinity
427 Bloor Street, West
Toronto, Ontario M5S 1X7

APPENDIX D

MOBILE VANS FOR HEALTH PROMOTION FOR SENIOR CITIZENS

Prepared by:

Sister Jean Golden, Calgary

Provincial Senior Citizens

Advisory Council Report, 1984

MOBILE VANS FOR HEALTH PROMOTION FOR SENIOR CITIZENS

Since one of the functions of local Health Units is to prevent illness, we would like to see the Department of Social Services and Community Health sponsor two health care mobile vans which could travel to senior residences, lodges, and senior centres. These vans could carry materials that would develop the holistic, preventive and self-care aspects of health. Such ideas are not new. In 1975 an International Symposium on "The Role of the Individual in Primary Health Control" was held in Denmark. In 1974 a federal report, "A New Perspective on the Health of Canadians," stated,

> *The Government of Canada now intends to give human biology, the environment and lifestyle as much attention as it has to the financing of the health care organization so that all four avenues to improved health care are pursued with equal vigor.*

(See Footnote 2, Section II.)

Meanwhile, physicians themselves have become promotors of self-care, initiating innovative projects and advising on others, as well as encouraging their patients to practice healthier habits. A few professional schools (The University of Alberta Faculty of Nursing, for example) have altered their curriculum to incorporate self-care. With the current financial pressures, it would seem wise for provincial governments to begin adopting self-care as an economic strategy, since many visits to doctors and hospitals could be avoided as people are educated to care more about and for themselves.

The health care vans could be attached either to urban or rural health units and could include

- A wellness/self-care module in which goals would be to define wellness, introduce the project, and outline the individual's responsibility for health and well-being.
- A self-care video area that could have slide-tape shows, filmstrips and video tapes that promote health development and preservation. These could be lent out as part of a lending library so they would be available for families and groups that have access to home and community audio-visual equipment.
- A theme display area, which could be changed at intervals, could deal with such things as fitness, nutrition, safety, emotional health, health hazards, stress management, medication awareness for seniors, the aging process, etc.

In other words, these areas would explain the purpose and components of a health promotion, injury and illness prevention program as well as reinforce concepts of personal responsibility and self care.

Such a self-care centre has been set up as a permanent self-care centre in the Alberta Children's Hospital in Calgary. However, a mobile unit would be more helpful for seniors. It must be understood that self-care is always undertaken in partnership with professionals and is not a substitute for professional care, but self-care is conducive to leading a life of wholeness, both physically and mentally.

APPENDIX E

SUMMARY OF LODGE STANDARDS

SUMMARY: MINIMUM STANDARDS FOR ALBERTA SENIOR CITIZENS' HOMES

This is a handbook for lodges that covers the purpose, food service, housekeeping, maintenance, health care and safety policies of the foundations that manage these senior citizens' homes.

The purpose of these foundations is to provide accommodation for elderly people in a home atmosphere; daily aids to living for the frail elderly in conjunction with other public service agencies; and opportunities for residents to participate in leisure, recreational and social activities which foster their continued involvement in family and community life. This purpose is achieved by providing the services listed below.

- The food service policy covers menu planning, meal services, food handling, hygiene, sanitation and safety in the kitchen. Besides the regular food service, provision is made for special medical diet requirements and for daily snacks. Emphasis is given to the proper storage and preparation of food and to the appearance, flavour and nutritive value of meals. Hygiene and kitchen safety are outlined.
- The housekeeping policy provides housekeeping in the residents' rooms and outlines how common areas are to be kept clean and free of hazards and odours. Safety for both residents and staff is an important part of this section and some standards are set for care in laundering linen.
- The maintenance policy emphasizes the need for preventive maintenance to ensure cost-efficient operation of the lodges by checks of equipment and electrical systems, maintenance of interiors, exteriors and furniture. Safety and maintenance are linked by directives for checking the condition of floor coverings, handrails and grab bars, directional signs and lighting, and for marking the edges of steps with a non-slip material.
- The safety policy seeks to provide a safe environment in which residents can live securely and staff can work safely. This policy covers a wide range of safety features and includes a fire safety/disaster plan, safety devices in building design and equipment, emergency lighting, resident indentification, emergency resident care, a list of which safety regulations are to be followed by each department in the lodge and a list of persons responsible for department safety precautions.

APPENDIX F

COMMENTS ON THE MODEL FOR AN ASSESSMENT AND PLACEMENT SERVICE

Submitted to the Minister of

Hospitals and Medical Care

August 1984

Provincial Senior Citizens

Advisory Council Report, 1984

Provincial Senior Citizens Advisory Council

10030 - 107 ST. · EDMONTON, ALBERTA · T5J 3E4 · 427-6437

August 7, 1984

Honourable David J. Russell
Minister
Hospitals and Medical Care
420 Legislature Building
Edmonton, Alberta
T5K 2B6

Dear Mr. Russell:

We are pleased to submit the comments of the Provincial Senior Citizens Advisory Council on the proposed assessment/placement model described in the discussion paper of the Interdepartmental Committee on Long Term Care.

Council members are very pleased with the steps that are being taken to implement a recommendation made in their 1983 report to the effect that Alberta needs a "single point of entry" for long term care services. We understand how difficult it is to achieve this as three different provincial departments are involved as well as many local authorities. We appreciate the work your committee is doing to achieve greater coordination in this area.

We support the proposed model in principle and are simply offering, in the attached paper with our comments, some suggestions for revision which we feel will make the model more effective. These relate to the size of the regions and the structure of the panel and the coordinating committee.

We have suggested that admission to lodges be handled through the assessment/placement service as admissions to other long term care facilities would be. Of the twelve members present, eight were in favour of this. Only four disagreed, feeling that lodges should continue to control their own admissions.

We hope the attached paper will be helpful to you in expediting this process and that within a short period of time you will test a model for an assessment/placement service in three regions of Alberta. If you have any questions about our comments, we shall be pleased to forward further information.

Sincerely,

Raymond Clark,
Chairman,
Provincial Senior Citizens
Advisory Council

Enclosure

Alberta
SOCIAL SERVICES
AND COMMUNITY HEALTH
Senior Citizens Bureau

COMMENTS ON THE ASSESSMENT/PLACEMENT MODEL

We support in principle the model for an assessment/placement service described in the discussion paper, as we believe (and have recommended) that there should be a single point of entry for all long term care services.

We see the proposed model as a beginning step towards achieving coordination through a single point of entry but would like to suggest a number of revisions which we believe would make the model more viable.

Design for the Model

Boundaries for the Regions -

We believe that the Hospital Utilization Regions are too large to be effective, particularly in the rural areas. Small regions would ensure that the persons involved in the placement process would be "closer" to the client. We have a fear of persons making decisions who do not know the community, its people and its facilities. In addition, the Hospital Utilization Committee Regions are so large and cross so many different service boundaries that the assessment-/placement system would be impersonal, cumbersome, impractical and costly.

We believe that the region for the model should be as small as possible but not more than a group of six nursing homes and auxiliary hospital districts (possibly as little as one) blended with Health Unit boundaries. Ideally, the region should not cross Health Unit boundaries.

Area Placement Panels -

In each nursing home and auxiliary hospital district within the region there should be an Area Placement Panel composed of representatives of the nursing home and auxiliary hospital, active treatment hospital, private nursing home, lodge foundation, Home Care, a physician and one or two persons at large. Each sector should appoint its own representative, and the persons at large should be appointed by the Regional Coordinating Committee. The Regional Coordinating Committee could assist in arranging for these appointments.

As in the model described in the discussion paper, Home Care (the nearest sub-office to the residence of the client) would provide the initial assessment/screening of all persons in need of long term care services, including those in active treatment hospitals whose residence is in the community. This would determine the level of care and, following discussion with the client and family, Home Care would arrange for needed community services, if appropriate.

Facility Placement -

If placement in a facility is needed, Home Care would refer the person to the Area Placement Panel (the residence of the client would determine the appropriate Panel) which would review the assessment and make the placement (based as much as possible on client choice). This Panel would meet on a regular basis and, like Home Care, would be able to call on other local expertise for consultation as well as on the Regional Coordinating Committee.

Regional Coordinating Committee -

At the regional level (a grouping of one to six nursing home and auxiliary hospital districts),

there would be a committee of experts appointed by the Minister of Hospitals and Medical Care and called the Regional Coordinating Committee. It would include a physician, a registered nurse, a rehabilitation therapist and a social worker, if possible.

The Regional Coordinating Committee would oversee the total process (though, except in problem situations, it would have little to do with clients receiving home care), would provide consultation services to the Area Placement Panels, handle appeals and have the authority to arrange for new assessments, and would report to the Minister on the overall functioning of the assessment and placement process in the region and on any special needs.

The Committee would also appoint the persons at large on the Area Placement Panels.

It is recognized that the Coordinating Committee, to be effective, would have to have paid staff services. This could be a person(s) hired directly by the Committee.

We have attached a design showing our conception of the assessment/placement process on this model.

Role of Lodges -

In the model in the discussion paper, lodges are to be represented on the Regional Coordinating Committee, but admissions to them would not necessarily have to be part of the assessment process. We suggest that they should be. Increasingly lodges are serving quite frail older persons, and such an assessment, while more detailed than the process presently used, could be most helpful to both the older client and the lodge administration (and also help to ensure that the lodge is the most appropriate facility for the individual).

Implementation -

We suggest that the model be tested in three regions, one urban and two rural, preferably one in the north and one in the south. There are great differences between urban and rural needs, and even among rural areas there are differences in geography and population characteristics.

The trial period for the models should be at least three years. Any service needs at least three years to become fully developed, to work out problem areas, and certainly this proposed model which represents a major change in procedures in Alberta needs at least a three year period for testing.

During these three years information should be collected on the health and social service needs of older persons, the appropriate mix of services and effective ways of delivering services. This information could be helpful for the whole province (particularly with one model in an urban area and two in rural areas).

Special Concerns -

The appeal process for clients is most essential. It would be necessary to monitor the appeal process carefully to ensure that appeals are handled promptly.

As much as possible there should be no unnecessary increases in personnel carrying out assessments; funds need to be directed into *services*.

The focal point for the whole assessment/placement process is the older person and, if available, his family. He and they should be involved at all points in the decision made. His choice should be respected, and as much as possible he should have significant input into major decisions

being made about his life. If he does not wish to receive a service (for example, placement in a facility), he should not be denied other services, provided they are less costly.

The assessment must look at the whole person and include social and psychological functioning and the family and the living situation. Home Care staff initiating the assessment process need expertise in assessment, along with an understanding of the treatment and rehabilitation potential of the elderly. Of crucial importance is an understanding of mental disability in older persons, and expert psychiatric consultation in this area is most important. Often elderly persons with curable conditions are denied proper care because their conditions have been misdiagnosed (for example, depression may be diagnosed as untreatable dementia).

We suggest, therefore, that continuing education of all persons involved in the assessment-/placement model is essential, and we would like to be assured that an education program will be built into the models established in pilot regions.

Concluding Comments

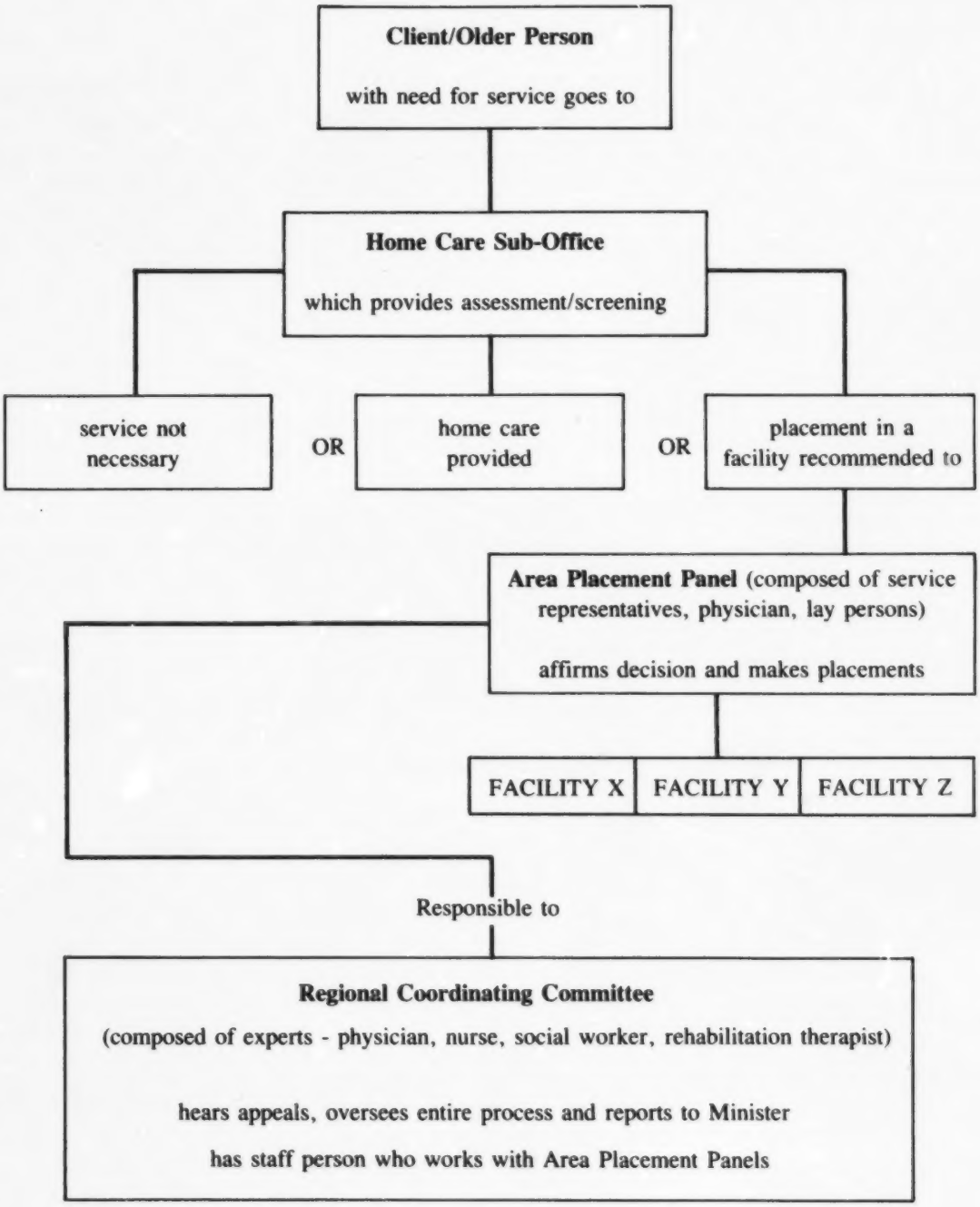
Cost increases for hospitalization of the elderly as estimated in the publication, *A Prognosis for Hospitals*, published by Statistics Canada in 1979, will increase from $5.4 billion in 1976 to a total of $11 billion in 2031. In 1976, $2.1 billion (38 percent of the total) was spent to hospitalize the elderly. In 2031 the projected cost is $11 billion with about two-thirds of the total cost spent on care of the elderly.

> *First, the resources must be found in the 1980s and 1990s to develop alternatives to institutional care, alternatives that support and maximize independent living and self-sufficiency. Second, because many of the residential care facilities and community based services required to prevent unnecessary hospitalization are funded by the social services and health systems, planning to meet these needs must be a joint effort between both systems. The natural tendency of the bureaucracies of these systems to plan within their own narrow jurisdictions will be a major deterrent to solving these issues.*
>
> (Canadian Council on Social Development, *Social Policies for the Eighties*, Ottawa, November, 1981.)

We are pleased with the initiative being taken by the Interdepartmental Committee on Long Term Care for it is a step in overcoming bureaucratic and other deterrents to effective and appropriate services for older people. This development has the potential of reducing in the long run the cost of care for older persons as it should reduce the proportion of those in costly facilities and do away with the present duplication of assessment by using existing resources more effectively (a most necessary step in a time of restraint).

More importantly, it has the possibility of providing more choice for older persons in need of help and involving them and their families more in the process.

MODEL FOR THE ASSESSMENT/PLACEMENT PROCESS


Client/Older Person
with need for service goes to
Home Care Sub-Office
which provides assessment/screening
service not necessary
OR
home care provided
OR
placement in a facility recommended to
Area Placement Panel (composed of service representatives, physician, lay persons)
affirms decision and makes placements
FACILITY X
FACILITY Y
FACILITY Z
Responsible to
Regional Coordinating Committee
(composed of experts - physician, nurse, social worker, rehabilitation therapist)
hears appeals, oversees entire process and reports to Minister
has staff person who works with Area Placement Panels

APPENDIX G

GERIATRIC EDUCATION AT THE UNIVERSITY OF CALGARY AND GERIATRIC SERVICES IN SOUTHERN ALBERTA

Prepared by:

Professor A.E.D. Schonfield,

Calgary

Provincial Senior Citizens Advisory

Council Report, 1984

GERIATRIC EDUCATION AT THE UNIVERSITY OF CALGARY AND GERIATRIC SERVICES IN SOUTHERN ALBERTA

Preamble

The proposed program in geriatrics at the University of Calgary was briefly mentioned in last year's Report, where we recommended that the three relevant government departments (Social Services and Community Health, Hospitals and Medical Care, Advanced Education) encourage and support such a development. This matter has continued to be a major concern of the Council during 1984 not only from the perspective of health needs of future elderly generations. Just as important will be the immediate effect of the presence of teachers of geriatrics attached to the University in overcoming the major deficiency in the provision of health services available to today's older population in Calgary and Southern Alberta. The reciprocal relationships between the quality of health services and geriatric education cannot be overemphasized. At present, there is not a single officially accredited geriatric specialist available to frail and sick elderly patients in Southern Alberta and experienced geriatricians will not be attracted there without a university base. Once there are university based geriatricians, they will establish facilities and delivery systems to serve as models for their students and will also practice in the community at large. Thus, a program in geriatrics at the University of Calgary is a necessary precondition for fulfillment of the Council's aims to improve the quality of care and cure, as well as prevention of illness among the elderly.

Functions of Geriatric Specialists

A speciality of geriatrics within medicine received official recognition in Canada only a few years ago, although in Britian it has some decades of history. Sir Fergusson Anderson, a leading British geriatrician, could, by 1974, say, "In regard to the future of geriatric medicine, the important point to stress is that as a specialty geriatric medicine has worked." (Anderson and Judge, 1984, p.307). Geriatricians do not supplant either the general practitioner or the variety of medical specialists, whose patients include a large proportion of elderly people. Indeed, the plethora of specific specializations, with the result that fewer physicians than heretofore have the interest, time and practical experience in dealing with all the problems of older patients, is an important reason why geriatrics has been welcomed as a new and valuable vocation. Another obvious reason is the great increase in the proportion of the population surviving into old age. By now, it is estimated that some 30 percent - 40 percent of medical time and health care expenditures are devoted to the elderly segment of the population (Rice and Feldman, 1983).

Descriptions of the functions of a geriatrician have occasionally been misinterpreted to imply some denigration of the skills and devoted attention given to elderly patients by physicians without official geriatric certification. Society will always need and appreciate such individuals, with their vast amount of experience, who will continue to bear the major medical responsibility for caring for the elderly.

The skills of a geriatrician are required because older patients, in contrast to the young, typically present multiple pathology. The variety of symptoms, sometimes emanating from in-

teracting causes, creates special problems in assessing aetiology, in reaching an adequate diagnosis and in deciding on suitable plans for treatment. It has always been tempting to attribute the medical problems of older patients to old age itself and the refrain of, "What else can you expect when you are old?" is still heard too often as the response to patient complaints. Separating illness from aging processes is a constant enigmatic problem in the medical diagnosis of older patients. Geriatrics, because of its links with other sub-disciplines of gerontology that study normal aging, emphasizes that old age is not a disease although aging processes may make an individual more vulnerable to environmental stress and make tissues more susceptible to disease. A special contribution of the geriatric specialist is to create a climate of optimism in the approach to older patients by assuming that the elderly person has the capacity to respond to treatment.

The interaction of environmental background and physical precipitating causes of illness among the aged demands of the geriatrician a breadth of knowledge and skills that other specialists do not possess. The aging dimension in medical practice constitutes the geriatrician's domain, but this must be combined with an ability to function as a member of a team in mobilizing community and family resources that permit patients, even patients who live alone, to stay in their own familiar surroundings, wherever possible.

On the strictly medical side, the skills and experience of a geriatrician are demanded both in diagnosis and treatment. For example, delirium can be caused by physical disorders and result in misdiagnosis of dementia, rather than an acute organic disorder. It has been estimated that misdiagnosis of dementia occurs in 10 percent - 30 percent of cases (U.S.A. Department of Health and Human Services, 1984). There are also special problems in clinical pharmacology, including: adverse drug reaction in the elderly; normal dosages being initially ineffective, followed by increasing dosage, without future reduction when the large dosage has become unwarranted and dangerous; large individual differences in response to drugs; prescriptions for a variety of ailments in the same individual with reciprocal inhibition or accentuation of drug effects. Interactions between physical and psychological symptoms are also of major concern to the geriatrician. Geriatric specialization cannot be completely separated from the new sub-specialty of psycho-geriatrics, since illnesses of old age frequently have a psychiatric aftermath, and physical symptoms can mask, and are sometimes caused by, psychiatric disturbance. A normal reaction of 'feeling blue' in response to losses encountered in the later years is not always easy to distinguish from depressive episodes or even from depressive psychosis. Assessment and treatment of patients exhibiting such symptoms depend on the geriatrician's ability to cooperate with members of the different professions working in the mental health field.

The foregoing brief and superficial description of functions is common to all geriatricians, but there is a very important divergence in emphasis among them. Although geriatricians, especially teachers of geriatrics, must have hospital beds available to them, some seem to operate exclusively in hospitals and similar institutions, whereas others devote much of their energy and time to elderly patients living at home. The most obvious distinction between the groups is that the latter place great emphasis on home visits and consultations with general practitioners.

This Council, with its well-known commitment to the value of home care, wishes to ensure that disciples of this school will be practicing in Alberta. Such geriatricians take the view that

observing a patient in her/his usual surroundings and obtaining information from relatives and professionals who have provided services to the patient is often a fundamental prerequisite for careful diagnosis and treatment decisions. They consider that the wide spectrum of professional and voluntary domiciliary services already available - from organized home help to chiropody and from neighbourly support to spiritual support - are part of their armamentarium. Only a small proportion of elderly with limitations in their daily living activities really require the costly transfer to institutions - costly with respect to finances, as well as quality of living. Even Alzheimer patients, at least in the early stages, are frequently able to remain in their own homes under the devoted care of families - usually the spouse - provided that respite is available for the 24-hour-a-day care giver. The presence of a geriatrician in the community should avoid increasing the demand for acute care beds in general hospitals and long-term care in auxiliary hospitals, although he/she would still require some hospital beds.

This portrait of the geriatrician is perhaps somewhat idealistic and it should be reemphasized that the skills and care provided by all physicians will continue as major pillars of medical services for the aged.

The geriatric specialist, however, has a leadership role to play in demonstrating excellence in medical care by example and in communicating relevant research findings to the medical fraternity. In the words of the 1981 White House Conference on Aging, "The quality of services available to the elderly depends on the quality of the personnel who provide them."

The University of Calgary

The Council has been informed of the steps taken by the Faculty of Medicine with respect to future geriatric education. First and foremost, there is now a firm commitment to enlarge and enrich the geriatric component of the undergraduate program, as well as to place increased emphasis on older patients throughout the curriculum. Secondly, the Dean established a Task Force on Geriatric Medicine, whose membership includes representatives from Foothills Hospital and Calgary Auxiliary Hospital and Nursing Home District No. 7 which is the major body with responsibilities for Calgary nursing homes and auxiliary hospitals. The Task Force arranged for a series of consulting visits by Dr. John Beck, a leading geriatrician practicing in California but originally from Canada, in addition to consultations with geriatric specialists and administrators from within and outside the Province. The Task Force has completed a preliminary report that recommends a focussed and limited thrust in two stages with the initial stage to be put in place during the coming two years and the following stage during the successive three years. The initial stage will utilize existing resources and those that can be made immediately available at Foothills Hospital. This will include a small geriatric observation and assessment unit of 6-12 beds, which will immediately result in medical students having some focussed clinical training in geriatrics. The following stage would involve the recruitment of three to five geriatric specialists, but there is no intent to embark on a new building program, as was done in Edmonton during the halcyon years of the economic boom. It is not anticipated that the Edmonton General Hospital Youville Geriatric Services model will be replicated, although the University of Calgary and Foothills Hospital have benefitted from the example.

The Council views the steps taken so far in Calgary as praiseworthy, and appreciates some of the complexities in planning a new recommendation of this kind and in bringing plans to fruition. Nevertheless, we are concerned at the slow pace in which future developments are likely to occur.

There seem to be two interconnected major obstacles that prevent the acceleration that we would like to see. There is the need to consult with, coordinate, and obtain approval from a variety of networks of committees, lines of administrative authority, governing boards and departments of government, each with separate constituencies.[1] Secondly, tightening of budgets over recent years leaves no money to spare. Unfortunately, these two obstacles constitute a vicious circle. Without money, planning has to be the responsibility of some of the most heavily burdened senior physicians, holding clinical and university appointments, whose constant first priority cannot be the approval and creation of an infrastructure for geriatric services and education. And until plans are agreed upon no requests for money can be made to the relevant government departments. The University even requires its formal approval before embarking on a possible private voluntary fund drive. The Alberta Heritage Foundation for Medical Research, which might seem an obvious source of seed monies, has enacted rules that seem to preclude funding of the proposed geriatric teaching unit. The Foundation can only provide monies for research, but without funds the people who would be eligible for research funding cannot be appointed.

The Council considered that the only way to ensure that a viable geriatric education group of the quality desired be established with dispatch is through a special grant. The size of the grant must be sufficient to cover the appointment of a senior geriatric specialist as the Head of Geriatrics at the University and Foothills Hospital. His/her main interest would of necessity be whatever is entailed in the establishing of a unit, including coordinating the multiplicity of committee efforts, so that a sense of urgency is engendered. Salaries of future members of the geriatric team would, to some extent, be covered through clincal practice in the community and joint appointments with hospitals. Research monies should also become available once the senior appointment is made and a fundraising drive would then also be feasible.

The development of a successful medical service, as with many other enterprises, is best achieved through cooperation from the outset between those who provide the service and the department of government which funds the program. In the case of universities, where independence is jealously guarded and cherished, issues of government or outside interference become particularly sensitive. It is therefore important that any government grant be made with minimal specific conditions. However, as has been reiterated in this Report, the community at large has an important stake in the establishment of a geriatric unit at the University, because of its impact on the quality of services available to the elderly population. Some of the advantages to the community will occur almost automatically through the presence of geriatricians at the University - more young doctors will develop interests in issues of aging at an early stage of their careers; mid-career retraining will become possible; continuing medical education in geriatrics will become available; research into problems of aging will increase. Other facets of geriatrics of concern to the Council might be given insufficient attention, in particular, an emphasis on care at home, teamwork with and joint training of other health professionals, and geriatric consultation in nursing homes. The Faculty of Medicine has demonstrated a special commitment to the community through the presence of flourishing Departments of Family Medicine and Community Health Sciences. Nevertheless, the fact that those with clincial practice in hospital surroundings predominate in the Task Force might result in neglect of bedside care experience in homes during training. As was earlier mentioned, some geriatricians seem to show such neglect and this is not the role model that future medical practitioners should receive. As a Canadian geriatrician has said, "Poorly understood or controlled social factors contribute also to illness and incapacity." (Bayne, 1977, p. 113.)

Teamwork with other health professionals is closely linked to community practice. In hospitals, the physician is king (or queen). Outside the pure medical setting, there is greater appreciation of the contributions of nurses, physiotherapists, clinical psychologists, social workers, etc., to care, cure, diagnose and prevent. Members of these professions, who work with aged clients, also require training, to which geriatric specialists must contribute partly in order to foster the team approach. The Task Force has enough to do without considering this issue at present, but from the Council's perspective, specialist training in gerontology and geriatrics for the various health professionals is a duty of universities that has still to be fulfilled.

Footnote

1. The two main institutions of concern are the University and Foothills Hospital and there at least some senior individuals can speak on behalf of both groups. At the University there is a ladder of academic committees leading to the General Faculties Council and the Board of Governors, as well as a bureaucracy through to the President with funding primarily being the responsibility of the Department of Advanced Education. Foothills Hospital has another structure leading to its Board of Directors and the Department of Hospitals and Medical Care. Links with the other Calgary teaching hospitals (General and Holy Cross) with their committees and governing bodies have to be considered, as well as Calgary Auxiliary Hospital and Nursing Home District No. 7 with its special responsibilities for auxiliary hospitals and nursing homes, Hospital District No. 93 which is responsible for one auxiliary hospital and the Calgary Area Health Authority.

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